LEA TARGETED CASE MANAGEMENT
LABOR SURVEY

School District _____ Contact Person _____

LEA Provider Number _____ Phone No. _____

Email Address _____

I. Provide the following information only for those employee classifications your district plans to use to provide TCM services:

Case Manager Classifications	**No. of TCM Case Managers**	**Annualized Salary Range**	**Annual Work Hours***
Registered Nurse			
Certified Nurse Practitioner			
Licensed Vocational Nurse			
Licensed Clinical Social Worker			
Licensed Marriage Family & Child Counselor			
Program Specialist			
Licensed Psychologist			
Credentialed School Psychologist			
Credentialed School Social Worker			
Credentialed School Counselor			
Credentialed School Principal - Special Education			
Credentialed School Teacher - Special Education			
Case Manager: Healthy Start or Special Education			

Other Classifications List (Attach Sheet If Required)

_____

_____

_____

* Standard annual work hours per classification is defined as 365 days x 8 hours, less: weekends, holidays, vacation, sick leave, bereavement, informal time off, jury duty, military leave, training.

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II. District Percentage Contribution for Staff Benefits

Retirement	_____
OASDI	_____
Health, Vision, Dental	_____
Other (List)	_____
TOTAL	_____

III. "Operating Expenses + Equipment *" per professional employee per year
$_____.

* supplies, equipment, printing, tuition, travel, etc.

IV. School Administration Overhead Rate *_____%

* Instructional Administration (EDP # 375, Col. 6) plus School Administration (EDP # 385, Col. 6), divided by Total Direct and Direct Support Costs (p. 6) from the annual Program Cost Data Report (J380).

V. CDE Approved Indirect Cost Rate _____%

VI. Other Information

a. Estimated number of Medi-Cal eligible Special Education Students with an IEP or IFSP served by the district annually _____.

b. Estimated total number of TCM Service Hours provided per month to all students identified in (a) _____.

VII. Certification

I certify that the financial information reported above is a true and correct reporting of the planned costs of the Local Educational Agency's (LEA's) participation in the LEA Medi-Cal Billing Option Targeted Case Management services.

_____ _____
Signature of Authorized Official Date

LEA Billing Option
Contact Person:_____ Phone #_____

School District:_____ Fax # _____

Street Address:_____

City, State, Zip:_____